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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
04/30/2022 3:11 PM
ARCHIVES DIVISION
SECRETARY OF STATE

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Minor Housekeeping Edits To Oregon Health Plan Managed Care Rules

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 05/21/2022 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

A public rulemaking hearing may be requested in writing by 10 or more people, or by a group with 10 or more members, within 21 days following the publication of the Notice of Proposed Rulemaking in the Oregon Bulletin or 28 days from the date the Notice was sent to people on the agency mailing list, whichever is later. If sufficient hearing requests are received, the notice of the date and time of the rulemaking hearing must be published in the Oregon Bulletin at least 14 days before the hearing.

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NEED FOR THE RULE(S)

Minor housekeeping edits are needed to align with Federal requirements, clarify language, remove outdated references, and correct typos.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

None

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

Implementing the aforementioned rule changes will clarify operational requirements for managed care entities that serve Oregon Health Plan members and are tasked with prioritizing health equity for Oregonians.

FISCAL AND ECONOMIC IMPACT:

The Department/Authority does not anticipate there will be a fiscal impact from these rule changes.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) The Department/Authority does not anticipate there will be a fiscal impact from these rule changes.
(2)
(a) None
(b) None

(c) None

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

None

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
410-141-3500, 410-141-3515, 410-141-3575, 410-141-3585, 410-141-3845, 410-141-3890, 410-141-3895, 410-141-3900, 410-141-3960

AMEND: 410-141-3500

RULE SUMMARY: Add definition for “Plan Type”

CHANGES TO RULE:

410-141-3500
Definitions
(1) The following definitions apply with respect to OAR chapter 410, division 141. The Authority also incorporates the definitions in OAR 410-120-0000, 309-032-0860 for any terms not defined in this rule.¶
(2) "Adjudication" means the act of a court or entity in authority when issuing an order, judgment, or decree, as in a final MCE claims decision or the Authority issuing a final hearings decision. For a final MCE claims decision, the date of "Adjudication" is the date on which an MCE has both (a) processed and (b) either paid or denied a Member's claim for services.¶
(3) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities, as set forth in OAR 410-120-0000.¶
(4) "Area Agency on Aging (AAA)" means the designated entity with which the Department contracts in planning and providing services to elderly populations, as set forth in OAR 410-120-0000.¶
(5) "The Authority" means the Oregon Health Authority.¶
(6) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide; CMS Section 1557 of the ACA outlines requirements for health plans and providers on alternative formats.¶
(7) "Auxiliary Aids and Services" means services available to members as defined in 45 CFR Part 92.¶
(8) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.¶
(9) "Benefit Period" means a period of time shorter than the five-year contract term, for which specific terms and conditions in a contract between a coordinated care organization and the Oregon Health Authority are in effect.¶
(10) "Business Day" means any day except Saturday, Sunday, or a legal holiday. The word "day" not qualified as business day means calendar day.¶
(11) "Capitated Services" means those covered services that an MCE agrees to provide for a capitation payment under contract with the Authority.¶
(12) "Capitation Payment" means monthly prepayment to an MCE for capitated services to MCE members.¶
(13) "Care Plan" means a documented plan that addresses the supportive, therapeutic, cultural, and linguistic health of a member. The member's care plan shall be developed for in collaboration with the Member and the Member's family or representative, and, if applicable, the Member's caregiver so that it incorporates their preferences and goals to ensure engagement and satisfaction. Care plans include, without limitation:¶
(a) ~~p~~Prioritized goals for a member's health;¶
(b) ~~i~~Identifying interventions and resources that will benefit and support the member's goals such as peer support, non-traditional services, community services, employment and housing support;¶
(c) ~~m~~Medication management; and¶
(d) ~~m~~Monitoring and re-evaluation.¶
(14) "CCO Payment" means the monthly payment to a CCO for services the CCO provides to members in accordance with the global budget.¶
(15) "Certificate of Authority" means the certificate issued by DCBS to a licensed health entity granting authority

to transact insurance as a health insurance company or health care service contractor.¶
(16) "Client" means an individual found eligible to receive OHP health services, whether or not the individual is enrolled as an MCE member.¶
(17) "Community Advisory Council (CAC)" means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members and the community consistent with ORS 414.625. CCOs shall seek an opportunity for tribal participation on CACs to bring nominee(s) to the attention of the CAC Selection Committee as follows:¶
(a) In a Service Area where only one federally recognized tribe exists, the CCO shall seek one tribal representative to serve on the CAC;¶
(b) In Service Areas where multiple federally recognized tribes exist, the CCO shall seek one tribal representative from each tribe to serve on the CAC; and¶
(c) In metropolitan Service Areas where no federally recognized tribe exists, CCOs shall solicit the Urban Indian Health Program for a representative to serve on the CAC.¶
(18) "Community Benefit Initiatives" (CBI) means community-level interventions focused on improving population health and health care quality.¶
(19) "Continuous Inpatient Stay" means an uninterrupted period of time that a patient spends as inpatient, regardless of whether there have been changes in assigned specialty or facility during the stay. This includes discharge transfer to another inpatient facility, in or out of state, such as another acute care hospital, acute care psychiatric hospital, skilled nursing facility, psychiatric residential treatment facility (PRTF) or other residential facility for inpatient care and services.¶
(20) "Contract" means an agreement between the State of Oregon acting by and through the Authority and an MCE to provide health services to eligible members.¶
(21) "Coordinated Care Organization (CCO)" means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.¶
(22) "Coordinated Care Services" mean an MCE's fully integrated physical health, behavioral health services, and oral health services.¶
(23) "Corrective Action" or "Corrective Action Plan" means an Authority-initiated request for an MCE or an MCE-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.¶
(24) "Delivery System Network" means the entirety of those Participating Providers who (a) contracts with, or (b) are employed by, an MCE for purposes of providing services to the Members of such MCE. "Provider Network" has the same meaning.¶
(25) "Dental Care Organization (DCO)" means a prepaid managed care health services organization that contracts, on a capitated basis, with the Authority under ORS 414.654 or with a coordinated care organization, or both with the Authority and a coordinated care organization, to provide dental services to medical assistance recipients. Dental Care Organization also meets the definition of a Prepaid Ambulatory Health Plan as defined under 42 CFR □ 438.2.¶
(26) "The Department" means the Department of Human Services.¶
(27) "Department of Consumer and Business Services (DCBS)" means Oregon's business regulatory and consumer protection department.¶
(28) "Disenrollment" means the act of removing a member from enrollment with an MCE.¶
(29) "Diversity of the Workforce" refers to the ethnic, racial, linguistic, gender, and social variation among members of the health professional workforce. It is generally understood that a more diverse workforce represents a greater opportunity for better quality health care service, due to the array of life experiences and empathy of a mix of providers that can be brought to the delivery of health care.¶
(30) "Encounter Data" means the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a State and a Managed Care Entity (MCE) that is subject to the requirements of □□ ORS 438.242 and ORS 438.818.¶
(31) "Enrollment" means the assignment of a member to an MCE for management and coordination of health services.¶
(32) "Family Planning" means services that enable individuals to plan and space the number of their children and avoid unintended pregnancies. The Oregon Health plan covers family planning services for clients of childbearing age, including minors who are considered to be sexually active. Family Planning services include:¶
(a) Annual exams;¶
(b) Contraceptive education and counseling to address reproductive health issues;¶
(c) Prescription contraceptives (such as birth control pills, patches or rings);¶
(d) IUDs and implantable contraceptives and the procedures requires to insert and remove them;¶

(e) Injectable hormonal contraceptives (such as Depo-Provera);¶
(f) Prescribed pharmaceutical supplies and devices (such as male and female condoms, diaphragms, cervical caps, and foams);¶
(g) Laboratory tests including appropriate infectious disease and cancer screening;¶
(h) Radiology services;¶
(i) Medical and surgical procedures, including vasectomies, tubal ligations and abortions.¶
(33) "Flexible Services" means those services that are cost-effective services offered as an adjunct to covered benefits.¶
(34) "Global Budget" means the total amount of payment as established by the Authority to a CCO to deliver and manage health services for its members including providing access to and ensuring the quality of those services.¶
(35) "Grievance System" means the overall system that includes:¶
(a) Grievances to an MCE on matters other than adverse benefit determinations;¶
(b) Appeals to an MCE on adverse benefit determinations; and¶
(c) Contested case hearings through the Authority on adverse benefit determinations and other matters for which the member is given the right to a hearing by rule or statute.¶
(36) "Health Literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.¶
(37) "Health-Related Services" means non-covered services under Oregon's Medicaid State Plan intended to improve care delivery and overall member and community health and well-being, as defined in OAR 410-141-3845. Health-related services include flexible services and community benefit initiatives.¶
(38) "Health System Transformation" means the vision established by the Oregon Health Policy Board for reforming health care in Oregon, including both the Oregon Integrated and Coordinated Health Care Delivery System and reforms that extend beyond the context of OHP.¶
(39) "Holistic Care" means incorporating the care of the entire member in all aspects of well-being including physical, psychological, cultural, linguistic, and social and economic needs of the member. Holistic care utilizes a process whereby providers work with members to guide their care and identify needs. This also involves identifying with principles of holism in a system of therapeutics, such as the practices of naturopathy or chiropractic and often involving nutritional measures.¶
(40) "Home CCO" means the CCO enrollment situation that existed for a member prior to placement, including services received through OHP fee-for-service, based on permanent residency.¶
(41) "Indian" and/or "American Indian/Alaska Native (AI/AN)" means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12; or as defined under 42 CFR 438.14(a).¶
(42) "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).¶
(43) "In Lieu of Service" (ILOS) means a setting or service determined by the Authority to be a medically appropriate and cost-effective substitute for a Covered Services consistent with provisions in OAR 410-141-3820. The utilization and actual cost of an ILOS is included in developing the components of the Capitation Payment. In lieu of services must meet the requirements of 42 CFR 438.3(e)(2).¶
(44) "Individual with Limited English Proficiency" means a person whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.¶
(45) "Institution for Mental Diseases (IMD)" means, as defined in 42 CFR § 435.1010, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing inpatient psychiatric services such as diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services. Its primary character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.¶
(46) "Intensive Care Coordination" (ICC) refers to the specialized services described in OAR 410-141-3870. These services have, in other contexts, been labeled Exceptional Needs Care Coordination.¶
(47) "Legal Holiday" means the days described in ORS 187.010 and 187.020.¶
(48) "Licensed Health Entity" means an MCE that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor.¶
(49) "Managed Care Entity (MCE)" means, an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, primary care case managers and Coordinated Care Organizations.¶
(50) "Managed Care Organization (MCO)" means a contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging, and making reimbursement arrangements for covered services as governed by state and federal law.

An MCO may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), or Physician Care Organization (PCO).¶
(51) "Material Change to Delivery System" means~~:~~:¶
(a) Any change to the CCOs Delivery System Network (DSN) that may result in more than five (5) percent of its Members changing the physical location(s) of where services are received; or¶
(b) Any change to CCO's DSN that would likely affect less than five (5) percent of its Members but involves a Provider or Provider group that is the sole provider specialty type; or¶
(c) Any change in CCO's overall operations that affects its ability to meet a required DSN standard including, but not limited to: termination or loss of a Provider or Provider group, or any change likely to affect more than five (5) percent of CCO's total Members or Provider Network or both; or¶
(d) Any combination of the above changes.¶
(52) "Medicaid-Funded Long-Term Services and Supports (LTSS)" means all Medicaid funded services CMS defines as long-term services and supports, including both:¶
(a) "Long-term Care," the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services, including state psychiatric hospitals;¶
(b) "Home and Community-Based Services," the Medicaid services and supports provided under a CMS-approved waiver to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Home and Community-Based Services (HCBS) and as outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services.¶
(53) "Member" means an OHP client enrolled with an MCE.¶
(54) "Member Representative" means an individual who can make OHP-related decisions for a member who is not able to make such decisions themselves.¶
(55) "National Association of Insurance Commissioners (NAIC)" means the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.¶
(56) "Non-Participating Provider" means a provider that does not have a contractual relationship with an MCE and is not on their panel of providers.¶
(57) "Ombudsperson Services" means patient advocacy services available through the Authority for clients who are concerned about access to, quality of, or limitations in the health services provided.¶
(58) "Oral Health" means conditions of the mouth, teeth, and gums.¶
(59) "Oregon Health Plan (OHP)" means Oregon's Medicaid program or related state-funded health programs. Any OHP contract shall identify whether it concerns Oregon's Medicaid program or a related state-funded health program, or both.¶
(60) "Oregon Integrated and Coordinated Health Care Delivery System" means the set of state policies and actions that promote integrated care delivery by CCOs to OHP clients, pursuant to ORS 414.620.¶
(61) "Participating Provider" means a provider that has a contractual relationship with an MCE. A Participating Provider is not a Subcontractor solely by virtue of a Participating Provider agreement with an MCE. "Network Provider" has the same meaning as Participating Provider.¶
(62) "Permanent Residency" means the county code-zip code combination of the physical residence in which the member/client lived, as found in the benefit source system, prior to placement and to which the member/client is expected to return to after placement ends.¶
(63) "Post-Hospital Extended Care Services" (PHECS). Consistent with 42 USC 1395x(i), PHECS means extended care services furnished an individual after transfer from a hospital in which a member was an inpatient for not less than 3 consecutive days before discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to a member after transfer from a hospital, and the member shall be deemed to have been an inpatient in the hospital immediately before transfer there from, if the member is admitted to the skilled nursing facility ~~(~~A:¶
(a) ~~w~~Within 30 days after discharge from such hospital, or ~~(~~B¶
(b) ~~w~~Within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 30 days after discharge from a hospital; and ~~a~~¶
(c) An individual shall be deemed not to have been discharged from a skilled nursing facility if, within 30 days after discharge therefrom, the member is admitted to such facility or any other skilled nursing facility.¶
(64) "Potential Member" means an individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific MCE.¶
(65) "Primary Care Provider (PCP)" means an enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified

clients. PCPs are health professionals who initiate referrals for care outside their scope of practice, consultations, and specialist care, and assure the continuity of medically appropriate client care. PCPs include:¶
(a) The following provider types: physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in this state, whose clinical practice is in the area of primary care;¶
(b) A health care team or clinic certified by the Authority as a PCPCH as defined in OAR 409-027-0005 and OAR 410-120-0000.¶
(66) "Provider" means an individual, facility, institution, corporate entity, or other organization that:¶
(a) Is engaged in the delivery of services or items or ordering or referring for those services or items; or¶
(b) Bills, obligates, and receives reimbursement from the Authority's Health Services Division on behalf of a Provider, (also termed a "Billing Provider");¶
(c) Supplies health services or items (also termed a "Rendering Provider").¶
(67) "Readily Accessible" means electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.¶
(68) "Service Area" means the geographic area within which the MCE agreed under contract with the Authority to provide health services.¶
(69) "Serious Emotional Disorder" (SED) means a subpopulation of individuals under age 21 who meet the following criteria:¶
(a) A child or youth, between the ages of birth to 21 years of age; and¶
(b) Must meet criteria for diagnosis, functional impairment and duration:¶
(A) Diagnosis: The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder):¶
(i) For children 3 years of age or younger. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised (DC: 0-3R) (or subsequent revisions);¶
(ii) For children 4 years of age and older. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Interview Schedule for Children (DISC) or DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder).¶
(B) Functional impairment: An individual is unable to function in the family, school or community, or in a combination of these settings; or the level of functioning is such that the individual requires multi-agency intervention involving two or more community service agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, or primary health care;¶
(C) Duration: The identified disorder and functional impairment must have been present for at least 1 year or, on the basis of diagnosis, severity or multi-agency intervention, is expected to last more than 1 year.¶
(70) "Special Health Care Needs" means individuals who have high health care needs, multiple chronic conditions, mental illness or Substance Use Disorders and either:¶
(a) Have functional disabilities;¶
(b) Live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care), or¶
(c) Are a Member of the Prioritized Populations as defined in OAR 410-141-3870.¶
(71) "Subcontract" means either:¶
(a) A contract between an MCE and a subcontractor pursuant to which such subcontractor is obligated to perform certain work that is otherwise required to be performed by the MCE under its contract with the State;; or¶
(b) Is the infinitive form of the verb "to Subcontract", i.e. the act of delegating or otherwise assigning to a Subcontractor certain work required to be performed by an MCE under its contract with the State.¶
(72) "Subcontractor" means an individual or entity that has a contract with an MCE that relates directly or indirectly to the performance of the MCE's obligations under its contract with the State. A Participating Provider is not a Subcontractor solely by virtue of having entered into a Participating Provider agreement with an MCE.¶
(73) "Trauma Informed Approach" means approach undertaken by providers and healthcare or human services programs, organizations, or systems in providing mental health and substance use disorders treatment wherein there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system and then takes into account those signs, symptoms, and their intensity and fully integrating that knowledge when implementing and providing potential paths for recovery from mental health or substance use disorders. The Trauma Informed Approach also

means that providers and healthcare or human services programs, organizations, or systems and actively resist re-traumatization of the individuals being served within their respective entities.¶
(74) "Temporary Placement" means, for purposes of this rule, hospital, institutional, and residential placement only, including those placements occurring inside or outside of the service area with the expectation to return to the Home CCO service area.¶
(75) "Trauma-informed services" means those services provided using a Trauma Informed Approach.¶
(76) "Treatment Plan" means a documented plan that describes the patient's condition and procedures that will be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the health care professional. This therapeutic strategy shall be designed in collaboration with the member, the member's family, or the member's representative.¶
(77) "Urban Indian Health Program" (UIHP) means an urban Indian organization as defined in section 1603 of Title 25 that has an IHS Title V contract as described in section 1653 of Title 25.¶
(78) "Workforce diversity capacity" means the organization's ability to foster an environment where diversity is commonplace and enhances execution of the organization's objectives. It means creating a workplace where differences demographics and culture are valued, respected and used to increase organizational capacity.¶
(79) "Plan Type" means the designation used by the Authority to identify which health care services covered by a client's OHP Plus or equivalent benefit package are paid by a CCO, by the Authority's fee-for-service program, or both. A client whose oral health services are paid by the fee-for-service program may be enrolled in a dental care organization (DCO) directly contracted by the Authority if the client's residence is covered by the DCO's service area. If a client does not have a plan type designation, then all of the client's health care services are paid by the fee-for-service program. Regardless of plan type, some health care services are carved out from CCOs by contract or rule and are instead paid by the fee-for-service program. The plan type designations are as follows:¶
(a) CCOA: Physical, oral, and behavioral health services are paid by the client's CCO;¶
(b) CCOB: Physical and behavioral health services are paid by the client's CCO. Oral health services are paid by the fee-for-service program;¶
(c) CCOE: Behavioral health services are paid by the client's CCO. Physical and oral health services are paid by the fee-for-service program;¶
(d) CCOG: Oral and behavioral health services are paid by the client's CCO. Physical health services are paid by the fee-for-service program;
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3515

RULE SUMMARY: 410-141-3515 (11) (d): Correct reference to behavioral health rule

CHANGES TO RULE:

410-141-3515
Network Adequacy
(1) MCEs shall maintain and monitor a network of participating providers that is sufficient in number, provider type, and geographic distribution to ensure adequate service capacity and availability to provide available and timely access to medically appropriate and culturally responsive covered services to both current members and those the MCE anticipate will become enrolled as members.¶
(2) The MCE shall develop a provider network that enables members to access services within the standards defined below.¶
(3) The MCE shall meet access-to-care standards that allow for appropriate choice for members. Services and supports shall be as close as possible to where members reside and, to the extent necessary, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations.¶
(4) MCEs shall meet quantitative network access standards defined in rule and contract.¶
(5) CCOs shall ensure access to integrated and coordinated care as outlined in OAR 410-141-3860, which includes access to a primary care provider or primary care team that is responsible for coordination of care and transitions.¶
(6) In developing its provider network, the CCO shall anticipate access needs so that the members receive the right care at the right time and place, using a patient-centered, trauma informed approach. The provider network shall support members, especially those with behavioral health conditions, in the most appropriate and independent setting, including in their own home or independent supported living.¶
(7) All MCEs shall ensure all members can access providers within acceptable travel time or distance requirements. Specifically:¶
(a) CCOs shall ensure all members can access the following provider and facility types within acceptable travel time or distance:-¶
(A) Mental health providers serving adults, serving pediatrics, and serving both adults and pediatrics;¶
(B) Oral health providers serving adults, serving pediatrics, and serving both adults and pediatrics;¶
(C) Specialty providers serving adults, serving pediatrics, and serving both adults and pediatrics;¶
(D) Substance use disorder providers serving adults, serving pediatrics, and serving both adults and pediatrics;¶
(E) Primary care providers serving adults, serving pediatrics, and serving both adults and pediatrics;¶
(F) Patient Centered Primary Care Homes;¶
(G) Federally Qualified Health Centers;¶
(H)-Hospital;¶
(I) Hospital, acute psychiatric care;¶
(J) Rural Health Centers;¶
(K) Pharmacies;¶
(L) Post-hospital skilled nursing facilities;¶
(M) Urgent Care Centers;-¶
(N) Additional provider types when it promotes the objectives of the Authority.¶
(b) DCOs directly contracted with the Authority must ensure all members have access to the following provider types within acceptable travel time and distance: denturist; expanded practice dental hygienists; dentofacial orthopedics; oral and maxillofacial pathologists; oral and maxillofacial surgeons; periodontists; orthodontists; endodontists; primary care dentists, adult; primary care dentists, pediatric; primary care dentist, both adult and pediatric, prosthodontics; registered dental hygienists; emergency dental services clinics; Federally Qualified Health Centers; Indian Health Services and Tribal Health Services; Public/County Health Departments; Rural Health Centers; and additional provider types when it promotes the objectives of the Authority.-¶
(c) All MCEs acceptable travel time and distance monitoring must assess the geographic distribution of providers relative to members and calculate driving time and distance from the member's physical address to the provider's location through the use of geocoding software or other mapping applications. Time and distance standards may not exceed the following, unless otherwise approved by the Authority:¶
(A) In urban areas, 30 miles, or 30 minutes;¶
(B) In rural areas, 60 miles, or 60 minutes.¶
(8) MCEs shall have an access plan that establishes a protocol for monitoring and ensuring access, outlines how provider capacity is determined, and establishes procedures for monthly monitoring of capacity and access and for improving access and managing access in times of reduced participating provider capacity. The access plan and associated monitoring protocol shall address the following:¶

(a) Expected utilization of services based on anticipated member enrollment and health care needs of the member population;¶
(b) The number and types of providers required to furnish the contracted services and the number and types of providers actively providing services within the MCE's current provider network;¶
(c) How the MCE will meet the accommodation and language needs of individuals with LEP as defined in OAR 410-141-3500 and people with disabilities in their service area in compliance with state and federal rules including but not limited to ORS 659A, Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973;¶
(d) The availability of telemedicine within the MCE's contracted provider network.¶
(9) CCOs shall make the services it provides (including primary care, specialists, pharmacy, hospital, vision, ancillary, and behavioral health services or other services as necessary to achieve compliance with the requirements of 42 CFR 438, subpart K) as accessible to members for timeliness, amount, duration, and scope as those services are to other patients within the same service area. If the MCE is unable to provide those services locally by providers qualified and specialized to treat a member's condition, it must arrange for the member to access care from providers outside the service area.¶
(10) MCEs shall have policies and procedures and a monitoring system to ensure that members who are aged, blind, or disabled, or who have complex or high health care needs, multiple chronic conditions, or have behavioral health conditions, or who are children receiving Department or OYA services have access to primary care, oral care (when the MCE or DCO is responsible for oral care), behavioral health providers, and referral, and involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services. Specifically, MCEs shall monitor and have policies and procedures to ensure:¶
(a) Access to providers of pharmacy, hospital, vision, ancillary, and behavioral health services;¶
(b) Priority access for pregnant women and children ages birth through five (5) years to health services, developmental services, early intervention, targeted supportive services, oral and behavioral health treatment.¶
(11) CCOs shall have policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit. The member shall be seen, treated, or referred within the following timeframes:¶
(a) Physical health:¶
(A) Emergency care: Immediately or referred to an emergency department depending on the member's condition;¶
(B) Urgent care: Within 72 hours or as indicated in initial screening and in accordance with OAR 410-141-3840;¶
(C) Well care: Within four weeks, or as otherwise required by applicable care coordination rules, including OAR 410-141-3860 through 410-141-3870.¶
(b) Oral and Dental care for children and non-pregnant individuals:¶
(A) Dental Emergency services as defined in 410-120-0000: Seen or treated within 24 hours;¶
(B) Urgent dental l care: Within two weeks;¶
(C) Routine oral care: Within eight weeks, unless there is a documented special clinical reason that makes a period of longer than eight weeks appropriate.¶
(c) Oral and Dental care for pregnant individuals:¶
(A) Dental Emergency services. Seen or treated within 24 hours;¶
(B) Urgent dental care, within one week;¶
(C) Routine oral care: Within four weeks, unless there is a documented special clinical reason that would make access longer than four weeks appropriate.¶
(d) Behavioral health:¶
(A) Urgent behavioral health care for all populations: Within 24 hours;¶
(B) Specialty behavioral health care for priority populations:¶
(i) In accordance with the timeframes listed below for assessment and entry, terms are defined in OAR 309-019-~~1~~0105, with access prioritized per OAR 309-019-0135. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services must be comparable to the original services requested based on the level of care and may include referrals, methadone maintenance, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135;¶
(ii) Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population: Immediate assessment and entry. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist;¶
(iii) IV drug users including heroin: Immediate assessment and entry. Admission for treatment in a residential level

of care is required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist;¶
(iv) Opioid use disorder: Assessment and entry within 72 hours;¶
(v) Medication assisted treatment: As quickly as possible, not to exceed 72 hours for assessment and entry;¶
(vi) Children with serious emotional disturbance as defined in OAR 410-141-3500: Any limits that the Authority may specify in the contract or in sub regulatory guidance.¶
(C) Routine behavioral health care for non-priority populations: Assessment within seven days of the request, with a second appointment occurring as clinically appropriate.¶
(12) MCEs shall implement procedures for communicating with and providing care to members who have difficulty communicating due to a medical condition, who need accommodation due to a disability, or who have Limited English Proficiency, living in a household where there is no adult available to communicate in English or there is no telephone:¶
(a) The policies and procedures shall ensure the provision of Oregon certified or Oregon qualified interpreter services by phone or in person if requested anywhere the member is attempting to access care or communicate with the MCE or its representatives;¶
(b) MCEs shall ensure the provision of certified or qualified interpreter services for all covered services including but not limited to, physical, behavioral health, or oral care (when the MCE or DCO is responsible for oral care) visits, and home health visits to interpret for members with hearing impairment or in the primary language of non-English-speaking members;¶
(c) All interpreters must be linguistically appropriate and capable of communicating in both English and the member's primary language and be able to translate clinical information effectively. Interpreter services must enable the provider to understand the member's complaint, make a diagnosis, respond to the member's questions and concerns, and communicate instructions to the member;¶
(d) MCEs shall ensure the provision of services that are culturally appropriate as described in National CLAS Standards, demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the member's care. Whenever possible MCEs shall ensure the provision of Oregon certified or Oregon qualified interpreters. If that is not possible then interpreters must adhere to generally accepted interpreter ethics principles, including client confidentiality; demonstrate proficiency in speaking and understand both spoken English and at least one other language; and must be able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology. For an individual with a disability, qualified interpreters can include, sign language interpreters, oral transliterators, and cued language transliterators as defined in 45 CFR 92.4;¶
(e) MCEs shall comply with requirements of the Americans with Disabilities Act of 1990 in providing access to covered services for all members and shall arrange for services to be provided by non-participating providers when necessary;¶
(f) MCEs shall collect and actively monitor data on language accessibility to ensure compliance with these language access requirements;¶
(g) MCEs shall report to the Authority such language access data and other language access related analyses in the form and manner set forth in this rule and as may otherwise be required in the MCE contract. The Authority shall provide supplemental instructions about the use of any required forms:¶
(A) Using the interpreter services self-assessment reporting template provided by the Authority, MCEs shall conduct an annual language access self-assessment and submit the completed language access self-assessment to the Authority on or before the third Monday of each January;¶
(B) MCEs shall collect and report language access and interpreter services to the Authority quarterly using the report form provided by the Authority. The quarterly due date for each Report is the first day of each calendar quarter, reporting data for the twelve (12) months ending one quarter before the due date. The first such twelve-month Report is due by April 1, 2022, for the twelve-month period from January 1, 2021, through December 31, 2021;¶
(C) MCEs shall complete and submit to the Authority any other language access reporting that may be required in the MCE contract.¶
(13) MCEs shall collect and actively monitor data on provider-to-enrollee ratios, interpretation utilization by the MCE and the MCE's provider network, travel time and distance to providers, percentage of contracted providers accepting new members, wait times to appointment (including specific data for behavioral health wait times), and hours of operation. MCEs shall also collect and actively monitor data on call center performance and accessibility for both member services and NEMT brokerage services call centers.¶
(14) MCEs must submit a Delivery System Network (DSN) report annually to the Authority that includes access data and other access-related analyses in the form and manner required by the Authority, including but not limited to capacity reports on:¶
(a) Behavioral health access;¶

(b) Interpreter utilization by the MCE's provider network;¶
(c) Behavioral health provider network.¶
(15) MCEs shall report the methodology for monitoring network adequacy to the Authority and the Authority-contracted External Quality Review Organization (EQRO).¶
(16) MCEs shall implement and require its providers to adhere to the following appointment and wait time requirements:¶
(a) A member may request to reschedule an appointment if the wait time for a scheduled appointment exceeds 30 minutes. If the member requests to reschedule, they shall not be penalized for failing to keep the appointment;¶
(b) MCEs shall implement written procedures and a monitoring system for timely follow-up with members when a participating provider has notified the MCE that the member failed to keep scheduled appointments. The procedures shall address:¶
(A) Timely rescheduling of missed appointments, as deemed medically appropriate;¶
(B) Documentation in the clinical record or non-clinical record of missed appointments;¶
(C) Recall or notification efforts; and¶
(D) Method of member follow-up.¶
(c) If failure to keep a scheduled appointment is a symptom of the member's diagnosis or disability or is due to lack of transportation to the MCE's participating provider office or clinic, MCEs shall provide outreach services as medically appropriate;¶
(d) Recognition of whether NEMT services were the cause of the member's missed appointment.¶
(17) CCOs must contract with the following specific provider types:¶
(a) Providers of residential chemical dependency treatment services;¶
(b) Any oral care organizations necessary to provide adequate access to oral services in the area where members reside.¶
(18) CCOs shall assess the needs of their membership and make available supported employment and Assertive Community Treatment services when members are referred and eligible:¶
(a) CCOs shall report the number of individuals who receive supported employment and assertive community treatment services, at a frequency to be determined by the Authority. When no appropriate provider is available, the MCE shall consult with the Authority and develop an approved plan to make supported employment and Assertive Community Treatment (ACT) services available;¶
(b) If 10 or more members in a CCO region have been referred, are eligible, and are appropriate for assertive community treatment, and have been on a waitlist to receive ACT for more than 30 days, CCOs shall take action to reduce the waitlist and serve those individuals by:¶
(A) Increasing team capacity to a size that is still consistent with fidelity standards; or¶
(B) Adding additional Assertive Community Treatment teams; or¶
(C) When no appropriate ACT provider is available, the CCO shall consult with the Authority and develop an approved plan to increase capacity and add additional teams.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3575

RULE SUMMARY: 410-141-3575 (1): Add definition for “Written Member Materials”

CHANGES TO RULE:

410-141-3575
MCE Member Relations: Marketing
(1) The following definitions apply for purposes of OAR 410-141-3575 through 410-141-3585:-¶
(a) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. This term includes, at a minimum, the types of alternate formats defined under the Americans with Disabilities Act (ADA) and 45 CFR Part 92, and shall include: braille, large (18 point) print, audio narration, oral presentation, electronic file, sign language interpretation, and sighted guide;-¶
(b) "Cold-call Marketing" means any unsolicited personal contact with a potential member for the purpose of marketing by the MCE;-¶
(c) "Marketing" means any communication from an MCE to a potential member who is not enrolled in the MCE that can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular MCE;-¶
(d) "Marketing Materials" means materials that are produced in any medium by or on behalf of an MCE and that can reasonably be interpreted as intended to market to potential members;-¶
(e) "Outreach" means any communication from an MCE to any audience that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular MCE. Outreach activities include, but are not limited to, the act of raising the awareness of the CCO, the MCE's subcontractors and partners, and the MCE contractually required programs and services; and the promotion of healthful behaviors, health education and health related events. For full benefit dual eligible (FBDE) members, outreach to provide information about opportunity to align Medicare and Medicaid benefits, or CMS approved Default or Simplified enrollment for newly Medicare eligible member in the CCO regarding MA or DSNP, is allowable subject to OHA or CMS materials review.¶
(f) "Outreach Materials" means materials that are produced in any medium, by or on behalf of an MCE that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular MCE;-¶
(g) "Potential Member" means, as defined in OAR 410-141-3500, a person who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific MCE;-¶
(h) "Prevalent Non-English Language" means all non-English languages that are identified during the eligibility process as the preferred written language by the lesser of:-¶
(A) Five percent of the MCE's total OHP enrollment; or-¶
(B) One thousand of the MCE's members;-¶
(i) "Readily Accessible" means electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.-¶
(C) "Written Member Materials" means informational and educational communications for members or potential members that are produced by or on behalf of an MCE in any written medium, including but not limited to: letters, brochures, guides, scripts, email, and text messaging. All written member materials must comply with the Authority's formatting and readability standards, as described in OAR 410-141-3585 and 42 CFR § 438.10, and be written in plain language sufficiently clear that a layperson could understand the information.¶
(2) MCEs shall comply with 42 CFR §§ 438.10, 438.100 and 438.104 to ensure that before enrolling OHP clients, the MCE provides accurate oral and written information that potential members need to make an informed decision on whether to enroll in that MCE. MCEs shall distribute the materials to its entire service area as indicated in its MCE contract. The MCEs may not:-¶
(a) Distribute any marketing materials without first obtaining state approval;-¶
(b) Seek to compel or entice enrollment in conjunction with the sale of or offering of any private insurance; and-¶
(c) Directly or indirectly engage in door to door, telephone, or cold-call marketing activities.-¶
(3) The following outreach to members or potential members are expressly permitted:-¶
(a) The creation of name recognition by an MCE. Permissible methods for creating name recognition include, but are not limited to, brochures, pamphlets, newsletters, posters, fliers, websites, bus wraps, bill boards, web banners, health fairs, or health-related events;-¶
(b) An MCE or its subcontractor's communications that express participation in or support for an MCE by its founding organizations or its subcontractors, so long as the communications do not constitute an attempt to compel or entice a client's enrollment;-¶
(c) The following communications related to full benefit dual-eligible (FBDE) members with affiliated or contracted MA or DSNP plans, and member's Medicare and Medicaid providers, as long as they do not constitute

an attempt by the MCE to influence client enrollment:-¶
(A) Communications to notify full benefit dual-eligible (FBDE) members of opportunities to align MCE-provided benefits with Medicare Advantage or Special Needs Plans or access ICC services;-¶
(i) Provision of information about CCO's affiliated Medicare Advantage Plan or Dual Special Needs Plan, contact information to inquire about the plan or provider network, and opt-in enrollment form;¶
(ii) Provision of aligned Medicare Advantage or Dual Special Needs Plan Simplified or Default enrollment letters, and CMS approved communication materials for newly eligible members.¶
(B) Improving coordination of care through mechanisms such as referral to LTSS assessment with DHS or providers of Home and Community Based Services, interdisciplinary care conferences, and use of HIE and event notifications;-¶
(C) Communicating with providers serving full benefit dual-eligible (FBDE) members about unique care coordination needs or member needs such as ICC services, service authorizations, goals to ensure preventive screenings and assessments are scheduled as recommended, auxillary aids and services or interpreter services; or ¶
(D) Streamlining communications to the full benefit dual eligible (FBDE) member to improve coordination of benefits including provision of integrated member materials, i.e. handbooks, provider directories, summary of Medicare-Medicaid benefits, and ID cards for members with aligned MA or DSNP and CCO enrollment.-¶
(4) MCEs shall update plan access information with the Authority on a monthly basis for use in updating the Authority's availability charts. The Authority shall confirm information before posting availability charts.-¶
(5) MCEs and when applicable, the aligned Medicare Advantage or Dual Special Needs Plan have sole accountability for producing or distributing materials following Authority approval.-¶
(6) MCEs shall comply with the Authority's marketing materials guidelines or other requirements for the submission, approval, review and correction of marketing materials or other communications with members or potential members. MCEs shall participate, as required, in development of guidelines or other requirements with the Authority through a transparent public process, including stakeholder input. The guidelines include, but are not limited to:-¶
(a) A list of communication or outreach materials subject to review by the Authority;-¶
(b) A clear explanation of the Authority's process for review and approval of marketing materials;-¶
(c) A marketing materials submission form to ensure compliance with MCE marketing rules; and-¶
(d) An update of plan availability information submitted to the Authority on a monthly basis for review and posting.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3585

RULE SUMMARY: 410-141-3585 (12) and (13): Remove individual criteria from rule and instead reference compliance with the Member Handbook Evaluation Criteria issued and updated by OHA every year.

410-141-3585 (14): Add language to clarify termination notice mailing timeline to align with 42 CFR 438.10 (f) (1). Renumber (13-15) after removing (13).

CHANGES TO RULE:

410-141-3585
MCE Member Relations: Education and Information
(1) MCEs may engage in activities for existing members related to outreach, health promotion, and health education. MCE must obtain approval of the Authority prior to distribution of any written communication by the MCE or its subcontractors and providers that:¶
(a) Is intended solely for members; and¶
(b) Pertains to requirements for obtaining coordinated care services at service area sites or benefits.¶
(2) MCEs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes or to enable care coordination and address social determinants of health or community health. The intent of these communications should be informational only for building community linkages to impact social determinants of health or member care coordination and not to entice or solicit membership. Communication methodologies may include but are not limited to brochures, pamphlets, newsletters, posters, fliers, websites, health fairs, or sponsorship of health-related events. MCEs shall address health literacy issues by preparing these documents at a low-literacy reading level, incorporating graphics and utilizing alternate formats.¶
(3) MCEs shall have a mechanism to help members understand the requirements and benefits of the MCE's coordinated care model. The mechanisms developed shall be culturally and linguistically appropriate. Written materials, including provider directories, member handbooks, appeal and grievance notices, and all denial and termination notices are made available in the prevalent non-English languages as defined in OAR 410-141-3575 in its particular service area and be available in formats noted in section (5) of this rule for members with disabilities. MCEs shall accommodate requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested.¶
(4) MCEs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. MCEs shall update their educational material as they add coordinated services. Member education shall:¶
(a) Include information about the coordinated care approach and how to navigate the coordinated health care system, including how to access Intensive Care Coordination (ICC) Services, and where applicable for Full Benefit Dual Eligible (FBDE) members, the process for coordinating Medicaid and Medicare benefits;¶
(b) Clearly explain how members may receive assistance from certified and qualified health care interpreters and Traditional Health Workers as defined in OAR 410-180-0305 and include information to members that interpreter services in any language required by the member, including American Sign Language, auxiliary aids and alternative format materials at provider offices are free to MCE members as stated in 42 CFR 438.10;¶
(c) Inform all members of the availability of Ombudsperson services.¶
(5) Written member materials shall comply with the following language and access requirements:¶
(a) Materials shall be translated in the prevalent non-English languages as defined in OAR 410-141-3575 in the service area as well as include a tagline in large print (font size 18) explaining the availability of written translation or oral interpretation to understand the information provided, as well as alternate formats, and the toll-free and TTY/TDY telephone number of the MCE's member/customer service unit;¶
(b) Materials shall be made available in alternative formats upon request of the member at no cost. Auxiliary aids and services must also be made available upon request of the member at no cost. The MCE's process for providing alternative formats and auxiliary aids to members may not in effect deny or limit access to covered services, grievance, appeals, or hearings;¶
(c) Electronic versions of member materials shall be made available on the MCE website, including provider directories, formularies, and handbooks in a form that can be electronically retained and printed, available in a machine-readable file and format, and Readily Accessible, e.g., a PDF document posted on the plan website that meets language requirements of this section. For any required member education materials on the MCE website, the member is informed that the information is available in paper form without charge upon request to Members and Member representatives, and the MCE shall provide it upon request within five business days.¶
(6) MCE provider directories shall be a single, comprehensive resource that encompasses the MCE's entire Provider Network, including any Providers contracted by Subcontractors that serve the MCE's Members. MCEs may not utilize a Subcontractor's separate or standalone provider directory to meet the Provider Directory

requirement and shall include:¶
(a) The provider's name as well as any group affiliation;¶
(b) Street address(es);¶
(c) Telephone number(s);¶
(d) Website URL, as appropriate;¶
(e) Provider Specialty, as appropriate;¶
(f) Whether the provider will accept new members;¶
(g) Whether the provider offers both telehealth and in-person appointments;¶
(h) Information about the provider's race and ethnicity, cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or an Authority-approved qualified and, as applicable, certified health care interpreter(s) at no cost to members at the provider's office;¶
(i) Availability of auxiliary aids and services for all members with disabilities upon request and at no cost;¶
(j) Whether the provider has completed cultural competence training as required by ORS 413.450 and in accordance to CCO Health Equity Plan Training and Education plan described in OAR 410-141-3735. Whether providers have verifiable language fluency in non-English (i.e., such as clinical training in a foreign country or clinical language testing);¶
(k) Whether the provider's office or facility is accessible and has accommodations for people with physical disabilities, including but not limited to information on accessibility of providers' offices, exam rooms, restrooms, and equipment.¶
(L) The information for each of the following provider types covered under the contract, as applicable to the MCE contract:¶
(A) Physicians, including specialists;¶
(B) Hospitals;¶
(C) Pharmacies;¶
(D) Behavioral health providers; including specifying substance use treatment providers;¶
(E) Dental providers.¶
(m) Information included in the provider directory shall be updated at least monthly, and electronic provider directories shall be updated no later than 30 days after the MCE receives updated provider information. Updated materials shall be available on the MCE website in a readily accessible and machine-readable file, e.g., a PDF document posted on the plan website, per form upon request and another alternative format.¶
(7) Each MCE shall make available in electronic or paper form the following information about its formulary:¶
(a) Which medications are covered both generic and name brand;¶
(b) What tier each medication is on.¶
(8) Within 14 days of an MCE's receiving notice of a member's enrollment, MCEs shall mail a welcome packet to new members and to members returning to the MCE 12 months or more after previous enrollment. The packet shall include, at a minimum, a welcome letter, a member handbook, and information on how to access a provider directory, including a list of any in-network retail and mail-order pharmacies.¶
(9) For existing MCE members, an MCE shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. MCEs shall send hard copies upon request within five days.¶
(10) MCEs must notify enrollees:¶
(a) That oral interpretation is available free of charge for any language, including American Sign Language, and written information is available in prevalent non-English languages as defined in OAR 410-141-3575 and alternate formats that include but are not limited to audio recording, close-captioned videos, large type (18 font), and braille;¶
(b) The process for requesting and accessing interpreters or auxiliary aids and alternative formats, including where appropriate how to contact specific providers responsible through sub-contracts to ensure provision of language and disability access;¶
(c) Language access services also applies to member representatives, family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care.¶
(11) An MCE shall electronically provide to the Authority for approval each version of the printed welcome packet that includes a welcome letter, member handbook, and information on how to access a provider directory.¶
(12) ~~The CCO member handbook shall be written in plain language using a font size no smaller than 12 point. At a minimum, the member handbook shall contain the following:¶~~
~~(a) Revision date including month, day, and year;¶~~
~~(b) Tag lines in English and other prevalent non-English languages, as defined in OAR 410-141-3575, spoken by populations of members. The tag lines shall be in large type (18 point font). The tag lines shall be located at the beginning of the document for the ease of the member and describe the following:¶~~
~~(A) How members may, at no cost to them, access sign language and oral interpreters, translations and materials in~~

alternate formats, and auxiliary aids and services;¶
(B) The toll-free and TTY/TDY telephone numbers of the MCE's customer service unit.¶
(c) CCO's office location, mailing address, web address, office hours, and telephone numbers including TTY;¶
(d) Explanation of access and care standards consistent with the requirements set forth in 42 CFR 438.206 and OARs 410-141-3515 and 410-141-3860;¶
(e) Availability and access to coordinated care services through a patient-centered primary care home or other primary care team with the member as a partner in care management. Explain how to choose a PCP, how to make an appointment, and how to change PCPs, and the CCO's policy on changing PCPs;¶
(f) Explanation of the health risk screening process;¶
(g) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;¶
(h) Explanation that American Indian and Alaskan Native members of the CCO may receive care from a tribal wellness center, Indian Health Services clinic, or the Native American Rehabilitation Association of the Northwest (NARA);¶
(i) Explanation of which participating or non-participating provider services the member may self-refer;¶
(j) Policies on referrals for specialty care, including prior authorization requirements and how to request a referral;¶
(k) Information on how to obtain a second opinion;¶
(L) Explanation of ICC services, including persons eligible as priority populations served and requirements for ICC care planning, and how eligible members may access those services;¶
(m) Information about the coordinated care approach, how to navigate the coordinated care health care system as applicable to dual-eligible individuals, and the process for coordinating Medicaid and Medicare benefits;¶
(n) Explanation of care coordination services and how the member can request and access a care coordinator;¶
(o) Information about the benefits and availability of Traditional Health Worker (THW) services as defined in OAR 410-180-0305, and how to contact the CCO's THW liaison;¶
(p) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;¶
(q) How and when members are to use emergency services, both locally and when away from home, including examples of emergencies and use of 911;¶
(r) Information on how to contact the CCO's in-house or subcontracted after-hours call-in system to triage Urgent Care and Emergency service calls from members or a member's long term care provider or facility.¶
(s) Information on contracted hospitals in the member's service area including hospital name, physical address, toll-free phone number, TTY, and webpage;¶
(t) Information on mobile crisis services and crisis hotline for members, including information that crisis response services are available 24 hours a day for members receiving Intensive In-Home Behavioral Health Treatment;¶
(u) Information on post-stabilization care after a member is stabilized in order to maintain, improve, or resolve the member's condition;¶
(v) Explanation of available telehealth services as described in OAR 410-141-3566 including, but not limited to, the information contained in sections (3) and (4) of OAR 410-141-3566, how to access telehealth services, and information on supports available to the member to assist them in accessing telehealth services;¶
(w) A statement or narrative that articulates the CCO's commitment to preventing fraud, waste, and abuse and complying with all applicable laws including, but not limited to, the State's False Claims Act and the federal False Claims Act;¶
(x) Information on where and how to report fraud, waste, or abuse by a provider or a member and a member's right to report fraud, waste, and abuse anonymously and be protected under applicable Whistleblower laws;¶
(y) Information on the CCO's grievance and appeals processes and the Authority's contested case hearing procedures, including:¶
(A) Information about assistance in filling out forms and completing the grievance process available from the CCO to the member as outlined in OAR 410-141-3875;¶
(B) Information about the member's rights in the grievance, appeals, and hearings process, including the right to continued benefits as provided in OAR 410-141-3885;¶
(C) The requirements and timeframes related to the processes for grievances, appeals, and hearings.¶
(z) Information on the member's rights and responsibilities, including the rights of minors, and availability of the Authority Ombudsperson;¶
(aa) Information on charges for non-covered services, and the member's possible responsibility for charges if they go outside of the CCO network for non-emergent care; including information specific to deductibles, copays and coinsurance for dually-enrolled qualified Medicare beneficiaries;¶
(bb) Information about when providers may bill clients for services and what to do if they receive a bill, including information specific to payment responsibilities for dually-enrolled qualified Medicare beneficiaries;¶

(cc) Information on coverage and billing for out of state services, including information how to access additional assistance from the CCO with a bill from an out of state provider and any appeal rights available to the member, if applicable;¶
(dd) Explanation of transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a PCP or PCD, other prescribing provider, or obtain new orders during that period; including how to access such services and specific communications for members who are becoming new Medicare enrollees;¶
(ee) Information on advance directive policies including:¶
(A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;¶
(B) The CCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience;¶
(C) Avenues for filing complaints concerning noncompliance with the Advance Directive requirements, including the grievance and hearings process or directly with the Authority, and information on how to file such a complaint with the Authority;¶
(ff) Whether or not the CCO uses provider contracts, including alternative payment methodologies or incentives, and how this will impact the member;¶
(gg) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee, and that they may request the record be amended or corrected;¶
(hh) How and when members are to obtain ambulance services;¶
(ii) Resources for help with transportation to appointments with providers and scheduling process for use of Non-Emergency Medical Transportation (NEMT) services;¶
(jj) All NEMT policies and procedures as outlined in OAR 410-141-3920 through 410-141-3965 and the CCO Contract, unless the member is provided with a stand-alone document, referred to as a "NEMT Rider Guide";¶
(kk) Explanation of the covered and non-covered services in sufficient detail to ensure that members understand the benefits to which they are entitled, including but not limited to;¶
(A) A delineation of the non-covered services the CCO coordinates from the non-covered services the CCO does not coordinate;¶
(B) Contact information for the Authority contractor responsible for coordination of non-covered services the CCO is not obligated to coordinate;¶
(C) Explanation that the CCO is responsible to arrange transportation for non-covered services that are coordinated by the CCO.¶
(LL) Information regarding any service not covered, in accordance with law, due to the religious or moral objections of the CCO and how to contact the Authority for information regarding accessing the service;¶
(mm) How to access in-network retail and mail-order pharmacies;¶
(nn) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs;¶
(oo) The CCO's confidentiality policy;¶
(pp) Explanation of the CCO's nondiscrimination policy and how and where to file a grievance if a member feels they were treated unfairly;¶
(qq) How and where members may access any benefits that are available under OHP but are not covered under the CCO's contract, including any cost sharing;¶
(rr) When and how members may voluntarily and involuntarily disenroll from CCOs and change CCOs;¶
(ss) Explanation of care and services available to members during a transition of care as defined in OAR 410-141-3850 and 42 CFR § 438.62, including CCO contact information to request more information regarding continued access to care and services during a transition of care and instructions on accessing the CCO's written transition of care policy;¶
(tt) CCOs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the CCO's internal changes. If changes affect the member's ability to use services or benefits, the CCO shall offer the updated member handbook to all members;¶
(uu) The "Oregon Health Plan Client Handbook" is in addition to the CCO's member handbook, and a CCO may not use it to substitute for any component of the CCO's member handbook.¶
(13) The DCO member handbook shall bMCE Member Handbooks shall comply with the Authority's formatting and readability standards and contain all elements outlined in the Member Handbook Evaluation Criteria issued by the Authority in accordance written in plain language using a font size no smaller than 12 point. The DCO member handbook is required for DCOs directly contracted by the Authority. At a minimum, the member handbook shall contain the following:¶
(a) The revision date, including month, day, and year;¶
(b) Tag lines in English and other prevalent non-English languages, as defined in as defined in OAR 410-141-3575,

spoken by populations of members. The tag lines shall be in large type (18-point font). The tag lines shall be located at the beginning of the document for the ease of the member and describe the following:¶
(A) How members may access free sign and oral interpreters, translations and materials in alternate formats, and auxiliary aids and services;¶
(B) The toll-free and TTY/TDY telephone numbers of the DCO's customer service unit.¶
(c) DCO's office location, mailing address, web address, office hours, and telephone numbers including TTY;¶
(d) The toll-free number for any partners providing services directly to members, including non-emergency medical transportation providers;¶
(e) The DCO's confidentiality policy;¶
(f) Information about the structure and operations of the DCO, including whether or not the DCO uses provider contracts, including alternative payment methodologies or incentives, and how this will impact the member;¶
(g) Explanation of oral health benefits and covered services available to members without charge in sufficient detail to ensure that members understand the benefits to which they are entitled;¶
(h) Explanation of care and services available to members during a transition of care as defined in OAR 410-141-3850 and 42 CFR 438.62, including DCO contact information to request more information regarding continued access to care and services during a transition of care and instructions on accessing the DCO's written transition of care policy;¶
(i) Explanation of transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a Primary Care Dentist (PCD), other prescribing provider, or obtain new orders during that period;¶
(j) Explanation of how to choose a PCD, how to make an appointment, how to change PCDs, and the DCO's policy on changing PCDs;¶
(k) Explanation that American Indian/Native Alaskan members may choose an Indian Health Care Provider (IHCP) as the member's PCD if:¶
(A) The IHCP is participating as a PCD within the provider network; and¶
(B) The member is otherwise eligible to receive services from such Indian Health Care Provider; and¶
(C) The IHCP has the capacity to provide the services to such members.¶
(L) Explanation that American Indian members may obtain covered services from non-participating providers and can be referred by an IHCP to a participating provider for covered services in accordance with 42 CFR 438.14;¶
(m) Explanation of access and care standards consistent with the requirements set forth in 42 CFR 438.206 and OARs 410-141-3515 and 410-141-3860;¶
(n) Explanation of available telehealth services as described in OAR 410-141-3566 including, but not limited to, the information contained in sections (3) and (4) of 410-141-3566, how to access telehealth services, and information on supports available to the member to assist them in accessing telehealth services;¶
(o) Explanation of the health risk screening process;¶
(p) Information about tobacco dependency and cessation services and how to access such services through the DCO;¶
(q) Explanation of non-emergency medical transportation (NEMT) services, including how the DCO coordinates NEMT services for members and how a member accesses NEMT services;¶
(r) Explanation of care coordination services and how the member can request and access a care coordinator, including information that the DCO must coordinate dental services furnished to the member with the services the member receives from other plans and/or from community and social support providers;¶
(s) Policies on referrals, prior authorization and pre-approval requirements and how to request a referral, including but not limited to the following:¶
(A) No prior authorization or referral is necessary for urgent or emergency dental services including dental post-stabilization services;¶
(B) Information on how to access specialty dental care furnished by the DCO;¶
(C) Information on how to access specialty care and other benefits that are not furnished by the DCO.¶
(t) Information on how to obtain a second opinion;¶
(u) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;¶
(v) Information regarding any service not covered, in accordance with law, due to the religious or moral objections of the DCO and how to contact the Authority for information regarding accessing the service;¶
(w) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;¶
(x) How and when members are to use emergency services, both locally and when away from home, including examples of dental emergencies and use of 911;¶
(y) Information on how to contact the DCO's after-hours call-in system to triage Urgent Care and Emergency service calls from members or a member's long-term care provider or facility;¶

~~(z) Explanation that members can access dental services while out of state in an urgent or emergency situation, including information on how to access additional assistance from the DCO with a bill from an out of state provider and any appeal rights available to the member, if applicable;¶~~
~~(aa) Information on when and how members may voluntarily and involuntarily disenroll from DCOs or change DCOs;¶~~
~~(bb) A statement or narrative that articulates the DCO's commitment to preventing fraud, waste, and abuse and complying with all applicable laws including, but not limited to, the State's False Claims Act and the federal False Claims Act;¶~~
~~(cc) Information on where and how to report fraud, waste, or abuse by a provider or a member and a member's right to report fraud, waste, and abuse anonymously and be protected under applicable Whistleblower laws;¶~~
~~(dd) Information on the DCO's grievance and appeals processes and the Authority's contested case hearing procedures, including:¶~~
~~(A) Information about assistance in filling out forms and completing the grievance process available from the DCO to the member as outlined in OAR 410-141-3875;¶~~
~~(B) Information about the member's rights in the grievance, appeals, and hearings process, including the right to continued benefits as provided in OAR 410-141-3885;¶~~
~~(C) The requirements and timeframes related to the processes for grievances, appeals, and hearings.¶~~
~~(ee) Information on the member's rights and responsibilities, including the rights of minors, and availability of the OHP Ombudsperson;¶~~
~~(ff) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee, and that they may request the record be amended or corrected;¶~~
~~(gg) Explanation of the DCO's nondiscrimination policy and how and where to file a grievance if a member feels they were treated unfairly, including contact information for the DCO's Non-discrimination coordinator;¶~~
~~(hh) Information about the requirement to provide providers and subcontractors with third-party liability information;¶~~
~~(ii) Explanation that the DCO will provide written notice to affected members of any significant changes in provider, program, or service sites that affect the member's ability to access care or services from the DCO's participating providers. Such notice shall be translated as appropriate and provided to the member at least 30 days before the effective date of the change, or as soon as possible if the participating provider has not given the DCO sufficient notification to meet the 30-day notice requirement;¶~~
~~(jj) Information on advance directive policies including:¶~~
~~(A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;¶~~
~~(B) The DCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience;¶~~
~~(C) Avenues for filing complaints concerning noncompliance with the Advance Directive requirements, including the grievance and hearings process or directly with the Authority, and information on how to file such a complaint with the Authority;¶~~
~~(kk) DCOs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the DCO's internal changes. If changes affect the member's ability to use services or benefits, the DCO shall offer the updated member handbook to all members;¶~~
~~(LL) The "Oregon Health Plan Client Handbook" is in addition to the DCO's member handbook, and an DCO may not use it to substitute for any component of the DCO's member handbook.~~h the requirements described in Exhibit B, Part 3, Section 5 of the Contract. ¶
(14) Member health education shall include:¶
(a) Information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. MCE providers or other individuals or programs approved by the MCE may provide health education. MCEs shall make every effort to provide health education in a culturally sensitive and linguistically appropriate manner in order to communicate most effectively with individuals from non-dominant cultures;¶
(b) Information specifying that MCEs shall not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of a member who is their patient for the following:¶
(A) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;¶
(B) Any information the member needs to decide among all relevant treatment options;¶
(C) The risks, benefits, and consequences of treatment or non-treatment.¶
(c) MCEs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Authority may assist in developing materials that address specifically identified health education problems to the population in need;¶

(d) An explanation of ICC services and how eligible members may access those services. MCEs should ensure that ICC related education reaches potentially eligible members, including those with special health care needs including those who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, chemical dependency, or who receive additional Medicaid-funded LTSS;¶
(e) The appropriate use of the delivery system, including proactive and effective education of members on how to access emergency services and urgent care services appropriately;¶
(f) MCEs shall provide written notice to affected members of any Material Changes to Delivery System as defined in OAR 410-141-3500 or any other significant changes in provider(s), program, or service sites that affect the member's ability to access care or services from MCE's participating providers. The MCE shall provide, translated as appropriate, the notice at least 30 days before the effective date of that change, or ~~as soon as possibl~~within 15 calendar days after receipt or issuance of the termination notice if the participating provider has not given the MCE sufficient notification to meet the 30-day notice requirement. The Authority shall review and approve the materials within two working days.¶
(15) MCEs shall provide an identification card to members, unless waived by the Authority, that contains simple, readable, and usable information on how to access care in an urgent or emergency situation. The cards are solely for the convenience of the MCE, members, and providers.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3845

RULE SUMMARY: 410-141-3845 (5): Remove outdated OAR reference.

CHANGES TO RULE:

410-141-3845
Health-Related Services
(1) The goals of Health-Related Services (HRS) are to promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being. Health-related services are provided as a supplement to covered health care services:¶
(a) HRS may be provided as flexible services or as community benefit initiatives, as those terms are defined below;¶
(b) CCOs have the flexibility to identify and provide health-related services beyond the list of examples in 45 CFR □□ 158.150, 158.151, as long as the HRS satisfy the requirements of this rule;¶
(c) As allowed under 42 CFR 438.6(e), MCEs may offer additional services that are separate from HRS and delivered at the complete discretion of the CCO;¶
(d) HRS may be used to pay for non-covered health care services including physical health, mental health, behavioral health, oral health, and tribal-based services.¶
(2) To qualify as an HRS within the meaning of this rule, a service must meet the following requirements, consistent with 45 CFR □ 158.150:¶
(a) The service must be designed to:¶
(A) Improve health quality;¶
(B) Increase the likelihood of desired health outcomes in a manner that is capable of being objectively measured and produce verifiable results and achievements;¶
(C) Be directed toward either individuals or segments of members, or provide health improvements to the population beyond those enrolled without additional costs for the non-members; and¶
(D) Be based on any of the following:¶
(i) Evidence-based medicine; or¶
(ii) Widely accepted best clinical practice; or¶
(iii) Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.¶
(b) The service must be primarily designed to achieve at least one of the following goals:¶
(A) Improve health outcomes compared to a baseline and reduce health disparities among specified populations;¶
(B) Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge;¶
(C) Improve patient safety, reduce medical errors, and lower infection and mortality rates;¶
(D) Implement, promote, and increase wellness and health activities;¶
(E) Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities above that are set forth in 45 CFR 158.151 that promote clinic community linkage and referral processes or support other activities as defined in 45 CFR 158.150.¶
(c) The following types of expenditures and activities are not considered HRS:¶
(A) Those that are designed primarily to control or contain costs;¶
(B) Those that otherwise meet the definitions for quality improvement activities but that were paid for with grant money or other funding separate from revenue received through a CCO's contract;¶
(C) Those activities that may be billed or allocated by a provider for care delivery and that are, therefore, reimbursed as clinical services;¶
(D) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 codes sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. □ 1320d-2, as amended;¶
(E) That portion of the activities of health care professional hotlines that do not meet the definition of activities that improve health quality;¶
(F) All retrospective and concurrent utilization review;¶
(G) Fraud prevention activities;¶
(H) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;¶
(I) Provider credentialing;¶
(J) Costs associated with calculating and administering individual member incentives; and¶
(K) That portion of prospective utilization that does not meet the definition of activities that improve health

quality.¶
(3) CCOs shall implement Policies and Procedures (P&Ps) for HRS. These P&Ps shall be submitted to the Authority for approval:¶
(a) HRS P&Ps shall encourage transparency and provider and member engagement, reflect streamlined administrative processes that do not create unnecessary barriers, and provide for accountability;¶
(b) A CCO's HRS spending on community benefit initiatives shall promote alignment with the priorities identified in the CCO's community health improvement plan, and with any HRS community benefit initiative spending priorities identified by the Authority;¶
(c) The P&P shall describe how HRS spending decisions are made, including the role of the CAC and tribes in community benefit initiatives spending decisions;¶
(d) CCOs shall not limit the range of permissible health-related services by any means other than by enforcing the limits defined in this rule.¶
(4) Flexible services are cost-effective services offered to an individual member as an adjunct to covered benefits. Flexible services shall be consistent with the member's treatment plan as developed by the member's care team and agreed to by the CCO. The care team and the CCO shall work with the member and, as appropriate, the family of the member in determining the HRS needed to supplement the member's care:¶
(a) CCOs shall provide members with a written notification of a refusal of individual flexible services request and shall copy any representative of the member and any provider who made or participated in the request on the member's behalf. The written notification shall inform the member and provider of the member's right to file a grievance in response to the outcome;¶
(b) A CCO's refusal to permit an individual flexible service request is not an "adverse benefit determination" within the meaning of OAR 410-141-3875. CCOs shall have written procedures to acknowledge the receipt, disposition, and documentation of each grievance from members, which shall be modelled on the procedures specified in 42 CFR 438.402-408 and OAR 410-141-3835 through 3915.¶
(5) Community benefit initiatives are community-level interventions that include, but are not necessarily limited to, members and are focused on improving population health and health care quality. CCOs shall designate a role for the community advisory council in health-related services community benefit initiative spending decisions ~~as provided in OAR 410-141-3735~~.¶
(6) CCOs shall submit their financial reporting for health-related services as directed through the CCO contract and in compliance with 42 CFR 438.8 Medical Loss Ratio (MLR).¶
(7) Except as provided in section (4), members have no appeal or hearing rights in regard to a refusal of a request for HRS.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042

AMEND: 410-141-3890

RULE SUMMARY: 410-141-3890 (1) (b): Remove inaccurate reference to filing an appeal if a member wants to contest an MCE's failure to act within appeal timeframes. Member would ask for a hearing in this case, not an appeal.

410-141-3890 (3) (c): Align appeal extension requirements with 42 CFR 438.408 (c) (2).

410-141-3890 (7): Align party requirements with 42 CFR 438.406 (b) (6).

410-141-3890 (11)(b)(E): Remove reference to hearing forms that are not specific to CCOs.

CHANGES TO RULE:

410-141-3890
Grievances & Appeals: Appeal Process
(1) A member, member representative, or a subcontractor or provider with the member's written consent, may file an oral or written appeal with the MCE to:¶
(a) Express disagreement with an adverse benefit determination; or¶
(b) ~~Contest the MCE's failure to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.¶~~
~~(c)~~ Oral appeals timeframes shall begin when there is established contact made between the member and an MCE representative. If the member leaves a voice mail message with the MCE indicating that they wish to appeal a denial the MCE shall make reasonable efforts (multiple calls at different times of day) to reach the member by phone to get the details of the service they wish to appeal. The MCE shall document each attempt to reach the member (date(s) and time(s)) by phone and make note of the date they establish contact with the member and are able to attain the appeal information needed to process the appeal.¶
(2) Each MCE may have only one level of appeal for members, and members shall complete the appeals process with the MCE prior to requesting a contested case hearing.¶
(3) For standard resolution of an appeal and notice to the affected parties, the MCE shall establish a timeframe that is no longer than 16 days from the day the MCE receives the appeal:¶
(a) If an MCE fails to adhere to the notice and timing requirements in 42 CFR § 438.408, the member is considered to have exhausted the MCE's appeals process. In this case, the member may initiate a contested case hearing;¶
(b) The MCE may extend the timeframes from section (3) of this rule by up to 14 days if:¶
(A) The member requests the extension; or¶
(B) The MCE shows to the satisfaction of the Authority upon its request that there is need for additional information and how the delay is in the member's interest.¶
(c) If the MCE extends the timeframes but not at the request of the member, the MCE shall:¶
(A) Make reasonable efforts (including as necessary multiple calls at different times of day) to give the member prompt oral notice of the delay;¶
(B) Within two days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision;¶
(C) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.¶
(4) For expedited resolution of an appeal please see OAR 410-141-3895. A request for an expedited appeal for a service that has already been provided to the member (post-service) will not be granted. The MCE shall transfer the appeal to the timeframe for standard resolution as set forth above in (3).¶
(5) For purposes of this rule, an appeal includes a request from the Authority to the MCE for review of a notice.¶
(6) A member or the provider on the member's behalf may request an appeal either orally or in writing directly to the MCE for any notice or failure to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of appeals by the MCE:¶
(a) The MCE shall ensure oral requests for appeal of a notice are treated as appeals to establish the earliest possible filing date;¶
(b) The member shall file the appeal with the MCE no later than 60 days from the date on the notice.¶
(7) Parties to the appeal include, as applicable:¶
(a) The ~~MCE~~member and the ~~member; or¶~~
~~(b) The MCE and the member's provider~~ir representative; or¶
(b) The legal representative of a deceased Member's estate.¶
(8) The MCE shall resolve each standard appeal in time period defined above in section (4) of this rule. The MCE shall provide the member with a notice of appeal resolution as expeditiously as the member's health condition requires, or within 72 hours for matters that meet the requirements for expedited appeals in OAR 410-141-3895.¶
(9) If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not

furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.¶
(10) If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the State shall pay for those services in accordance with the Authority policy and regulations.¶
(11) The written notice of appeal resolution shall be in a format approved by the Authority. The notice shall contain, as appropriate, the same elements as the notice of action/adverse benefit determination, as specified in OAR 410-141-3885, in addition to:¶
(a) The results of the resolution process and the date the MCE completed the resolution; and¶
(b) For appeals not resolved wholly in favor of the member:¶
(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;¶
(B) The right to request a contested hearing or expedited hearing with the Authority and how to do so;¶
(C) The right to request to continue receiving benefits while the hearing is pending and how to do so; and¶
(D) An explanation that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCE's adverse benefit determination;¶
(E) Copies of the appropriate forms:¶
~~(i) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or¶~~
~~(ii)~~ Request to Review a Health Care Decision Appeal and Hearing Request form (OHP 3302) or approved facsimile.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3895

RULE SUMMARY: 410-141-3895 (4)(e)(A): Align expedited appeal extension requirements with 42 CFR 438.408 (c) (2)

CHANGES TO RULE:

410-141-3895
Grievances & Appeals: Expedited Appeal
(1) Each MCE shall establish and maintain an expedited review process for all oral and written appeals when the member or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function as set forth in OAR 410-120-1860. Oral appeals timeframes shall begin when there is established contact made between the member and an MCE representative.¶
(2) The MCE shall ensure that punitive action is not taken against a provider who requests an expedited resolution.¶
(3) A request for an expedited appeal for a service that has already been provided (post-service) to the member will not be granted. The MCE shall transfer the appeal to the timeframe for standard resolution as set forth in 410-141-3890 (4).¶
(4) For expedited resolution of an appeal and notice to affected parties, the MCE shall complete the review of the expedited appeal in a timeframe that is no longer than 72 hours after the MCE receives the appeal. The MCE shall:¶
(a) Inform the member of the limited time available for receipt of materials or documentation for the review;¶
(b) Make reasonable efforts to call the member and the provider to tell them of the resolution within 72 hours after receiving the request;¶
(c) Mail written confirmation of the resolution to the member within three days;¶
(d) Extend the timeframes by up to 14 days if:¶
(A) The member requests the extension; or¶
(B) The MCE shows (to the satisfaction of the Authority upon its request) that there is need for additional information and how the delay is in the member's interest.¶
(e) If the MCE extends the timeframes not at the request of the member, the MCE shall:¶
(A) Make reasonable efforts (including as necessary multiple calls at different times of day) to give the member prompt oral notice of the delay;¶
(B) Within two days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.¶
(5) If the MCE provides an expedited appeal but denies the services or items requested in the expedited appeal, the MCE shall inform the member of the right to request an expedited contested case hearing and shall send the member a Notice of Appeal Resolution, in addition to Hearing Request and Information forms as set forth in OAR 410-141-3890.¶
(6) If the MCE denies a request for expedited resolution on appeal, the MCE shall:¶
(a) Transfer the appeal to the timeframe for standard resolution in accordance with OAR 410-120-1860;¶
(b) Make reasonable efforts to give the member and requesting provider prompt oral notice of the denial and follow up within two days with a written notice.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-141-3900

RULE SUMMARY: 410-141-3900 (2) (a): Replace reference to general hearing form with CCO-specific hearing form.
410-141-3900 (5): Align party requirements with 42 CFR 438.408 (f) (3).

CHANGES TO RULE:

410-141-3900
Grievances & Appeals: Contested Case Hearings
(1) An MCE shall have a system in place to ensure its members and providers have access to appeal for MCE's action by requesting a contested case hearing:¶
(a) Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. Processes for contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures;¶
(b) If a provider filed an appeal on behalf of a member, as permitted in OAR 410-141-3890, the provider may subsequently request a contested case hearing on behalf of the member in accordance with the procedures in this rule;¶
(c) Appeals brought on the provider's own behalf are not subject to this rule, which governs appeals brought by member or by a provider on the member's behalf but are governed by OAR 410-120-1560.¶
(2) The member may not proceed to a hearing without first completing an appeal with their MCE and receiving written notice that the MCE adverse benefit determination is upheld, subject to the exception under section (3) of this rule, below:¶
(a) The member shall file a hearing request with the Authority using form ~~MSC 0443~~OHP 3302 or any other Authority-approved appeal or hearing request form no later than 120 days from the date of the MCE's notice of appeal resolution. The Authority shall consider the request timely with the exception as noted for expedited hearing requests in OAR 410-141-3905;¶
(b) If the member sends a contested case hearing request directly to the Authority and the Authority determines that the member qualifies for a contested case hearing, the MCE shall submit the required documentation to the Authority's Hearings Unit within two business days of the Authority's request;¶
(c) If the member files a request for an appeal or contested case hearing with the Authority prior to the member filing an appeal with the MCE, and if the request does not satisfy section (3) below, the Authority shall transfer the request to the MCE and provide notice of the transfer to the member. The MCE shall:¶
(A) Review the request immediately as an appeal of the MCE's notice of adverse benefit determination;¶
(B) Respond to the request for the appeal within 16 days and provide the member with a notice of appeal resolution.¶
(d) If a member sends the contested case hearing request to the MCE after the MCE has already completed the initial plan appeal, the MCE shall:¶
(A) Date-stamp the hearing request with the date of receipt; and¶
(B) Submit the following required documentation to the Authority within two business days:¶
(i) A copy of the hearing request notice of adverse benefit determination, and notice of appeal resolution;¶
(ii) All documents and records the MCE relied upon to take its action, including those used as the basis for the initial action or the notice of appeal resolution, if applicable, and all other relevant documents and records the Authority requests as outlined in detail in OAR 141-410-3890.¶
(3) If, after a member properly files an appeal, the MCE fails to adhere to the notice and timing requirements in 42 CFR 438.408, the Authority may consider the member to have exhausted the MCE's appeals process for purposes of requesting a contested case hearing, as provided in OAR 410-141-3890(3). The Authority shall notify the MCE of the Authority's decision to allow the member access to a contested case hearing.¶
(4) Effective February 1, 2012, the method described in OAR 137-003-0520(8)-(10) is used in computing any period of time prescribed in OAR chapter 410, divisions 120 and 141 applicable to timely filing of requests for hearing. However, due to operational conflicts, the procedures needing revision, and the expense of doing so, the provisions in OAR 137-003-0520(9) and 137-003-0528(2) that allow hearing requests to be treated as timely based on the date of postmark do not apply to MCE member contested case hearing requests.¶
(5) The parties to a contested case hearing include ~~the following~~, as applicable:¶
(a) The ~~MCE~~member and the ~~member; or~~¶
~~(b) The MCE and the member's provider~~ir representative; or¶
(b) The legal representative of a deceased Member's estate; and¶
(c) The MCE.¶
(6) The Authority shall refer the hearing request along with the notice of adverse benefit determination or notice of appeal resolution to the Office of Administrative Hearings (OAH) for hearing. Contested case hearings are

requested using Authority form MSC 443 or other Authority-approved appeal or hearing request forms.¶
(7) The Authority shall issue a final order, or the Authority shall resolve the case ordinarily within 90 days from the date the MCE receives the member's request for appeal. The 90-day count does not include the days between the date the MCE issued a notice of appeal resolution and the date the member filed a contested case hearing request.¶
(8) For reversed appeal and hearing resolution services:¶
(a) For services not furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination;¶
(b) For services furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the state shall pay for those services in accordance with the Authority policy and regulations.
Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635, 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

AMEND: 410-141-3960

RULE SUMMARY: 410-141-3960 (7): Add language to clarify travel requirement

CHANGES TO RULE:

410-141-3960
Transportation: Member Reimbursed Mileage, Meals, and Lodging
(1) A CCO may prior authorize a member's mileage, meals, and lodging to covered medical service in order for the member to qualify for reimbursement.¶
(2) A CCO may disallow a client reimbursement request received more than 45 days after the travel.¶
(3) A CCO shall reimburse a member for mileage, meals, and lodging at rates not less than the Authority's allowable rates. The OHP fee schedule is available on the Authority's website.¶
(4) The member must return any documentation a CCO requires before receiving reimbursement.¶
(5) A CCO may hold reimbursements under the amount of $10 until the member's reimbursement reaches $10.¶
(6) A CCO shall reimburse members for meals when a member travels:¶
(a) Out of their local area as outlined in OAR 410-141-3515(4)(a) and (b); and¶
(b) For a minimum of four hours round-trip.¶
(7) A CCO's brokerage or other transportation subcontractor shall reimburse members for lodging when:¶
(a) A member would otherwise be required to begin travel before 5 a.m. in order to reach a scheduled appointment; or¶
(b) Travel from a scheduled appointment would end after 9 p.m.; or¶
(c) The member's health care provider documents a medical need.¶
(8) A CCO may reimburse members for lodging under additional circumstances at the CCO's discretion.¶
(9) A CCO shall reimburse for meals or lodging for one attendant, which may be a parent, to accompany the member if medically necessary, if:¶
(a) The member is a minor child and unable to travel without an attendant;¶
(b) The member's attending physician provides a signed statement indicating the reason an attendant must travel with the member;¶
(c) The member is mentally or physically unable to reach their medical appointment without assistance; or¶
(d) The member is or would be unable to return home without assistance after the treatment or service.¶
(10) A CCO may reimburse members for meals or lodging for additional attendants or under additional circumstances at the CCO's discretion.¶
(11) A CCO may recover overpayments made to a member. Overpayments occur when a CCO's brokerage or other transportation subcontractor paid the member:¶
(a) For mileage, meals, and lodging, and another resource also paid:¶
(A) The member; or¶
(B) The ride, meal, or lodging provider directly;¶
(b) Directly to travel to medical appointments, and the member did not use the money for that purpose, did not attend the appointment, or shared the ride with another member whom the brokerage also paid directly;¶
(c) For common carrier or public transportation tickets or passes, and the member sold or otherwise transferred the tickets or passes to another individual.¶
(12) If an individual or entity other than the member or the minor member's parent or guardian provides the ride, a CCO's brokerage or other transportation subcontractor may reimburse the individual or entity that provided the ride.
Statutory/Other Authority: ORS 413.042~~, ORS 414.625~~
Statutes/Other Implemented: ~~ORS 414.625~~